ADVANCE MEDICAL GROUP

BOARD CERTIFIED
INTERNAL MEDICINE · FAMILY PRACTICE · BARIATRIC

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Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____
Birth Date:_____

I HEREBY AUTHORIZE Advance Medical Group:
Any of my medical/dental information, **including information about**:
Sexually transmitted disease (STD) testing and treatment* HIV/AIDS testing and treatment*
Mental health diagnoses and treatment* Pregnancy testing and prenatal care*
Drug and alcohol use history and treatment* Birth control/family planning*
My lab results ***(note: signing this form does NOT mean we will share result of STD or HIV/AIDS tests)***
My appointment times, dates, and reasons for the visits
The medications I am taking
The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to NJIM Medical Records), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires: When I cancel it in writing _____
If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

Signature: _____ Date: _____
*Relationship to minor patient (if parent or legal guardian)**: _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)
Witness: _____ Date: _____